AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, APRIL 3, 2017

3:00 P.M. - STATE CAPITOL ROOM 444

ITEMS TO BE HEARD

LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: MEMBER PROPOSAL AND UPDATE ON NALOXONE FUNDING

PANEL

- **Assemblymember Marie Waldron**
- **Greg Oliva**, MPH, Assistant Deputy Director, Center For Chronic Disease Prevention and Health Promotion, Department of Public Health
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: SUBSTANCE USE SERVICES AND WORKLOAD BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 3: SUICIDE PREVENTION OVERSIGHT AND STAKEHOLDER PROPOSAL

PANEL 1: EXPERTS

- **Rebecca Anne Bernert**, PhD, Assistant Professor, Stanford University
- **Anara Guard**, Public Health Consultant
- **Theresa Ly**, MPH, Program Manager, California Mental Health Services Authority (CalMHSA)
- **Lyn Morris**, MFT, Senior Vice President, Clinical Operations, Didi Hirsch Mental Health Services

PANEL 2: ADMINISTRATION & LAO

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 4: PROPOSITION 63 FISCAL REVERSIONS

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

ISSUE 5: CHILDREN'S MENTAL HEALTH CRISIS SERVICES AND COMMUNITY INFRASTRUCTURE GRANTS

PANELISTS

- California Health Facilities Financing Authority
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 6: COMMISSION OVERVIEW AND BUDGET

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 7: PREVENTION AND EARLY INTERVENTION PLAN REVIEWS BUDGET CHANGE PROPOSAL

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 8: CONTRACTS ADMINISTRATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 9: MENTAL HEALTH WORKFORCE EDUCATION AND TRAINING (WET) PROGRAM OVERSIGHT AND STAKEHOLDER PROPOSAL

PANELISTS

- **Stacie Walker,** Deputy Director for the Healthcare Workforce Development Division**,** Office of Statewide Health Planning & Development
- **Rusty Selix**, Director, Public Policy & Advocacy, California Council of Community Behavioral Health Agencies
- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- County Behavioral Health Directors Association of California (*invited*)
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 10: COMMUNITY MENTAL HEALTH SERVICES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 11: DELAYS IN IMPLEMENTATION OF THREE BILLS (TRAILER BILL)

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ITEMS TO BE HEARD

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: MEMBER PROPOSAL AND UPDATE ON NALOXONE FUNDING

PANELISTS

- **Assemblymember Marie Waldron**
- **Greg Oliva**, MPH, Assistant Deputy Director, Center For Chronic Disease Prevention and Health Promotion, Department of Public Health
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

This issue covers the following two issues:

1. Assemblymember Waldron has submitted a proposal to the Subcommittee to appropriate $20 million to the Department of Public Health (DPH) for purposes of establishing and operating an opioid use prevention program.

2. The 2016 Budget Act includes $3 million one-time General Fund for the purpose of distributing Naloxone, an overdose prevention medication, and the Subcommittee requests DPH to provide an update on these funds.

BACKGROUND

Assemblymember Waldron Proposal
Assemblymember Waldron proposes to appropriate $20 million to DPH to coordinate a widespread public awareness campaign with culturally relevant educational materials and digital media to prevent new Opioid and Heroin addictions and give information on prevention, risks, treatment and resource options that may be available. Assemblymember Waldron states that: "The coordinated and widespread dissemination of culturally relevant educational materials, which are appropriately tailored to appeal to different target audiences, will raise awareness to prevent new addictions and give information on available resources and services. Prioritizing funding to create that education network is paramount in order to save lives and the costly effects of this epidemic."

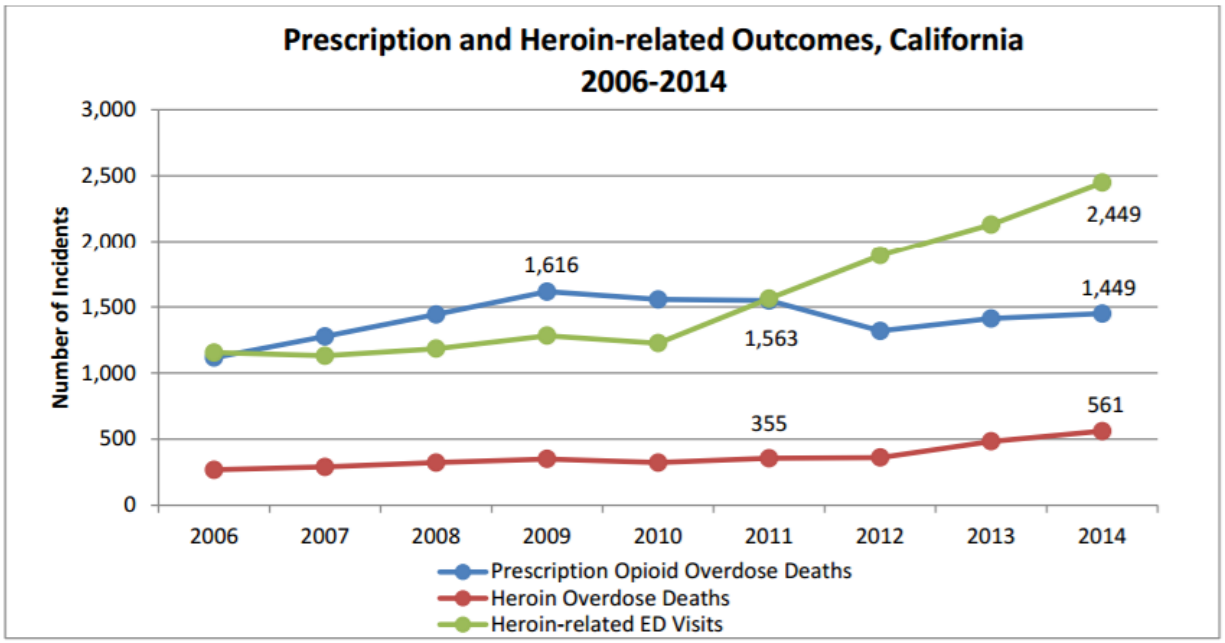
Background on the Opioid Overdose Epidemic and the State's Response

Nationally, the rates of fatal drug overdoses doubled over the last ten years, making it a leading cause of preventable death. Prescription opioids are the most common drug used in these deaths. According to Department of Public Health Vital Statistics Data, there were 3,375 deaths in California in 2013 from opioid-related overdoses. DPH recently issued an informational update to the Legislature that states:

> "Prescription medication misuse and overdose is a national epidemic, according to the Centers for Disease Control and Prevention (CDC). When it comes to unintentional injury deaths in the U.S., more people die from prescription medication overdoses than in motor vehicle crashes. In 2014 in the U.S., more than 28,000 people died from opioid overdose, with 14,000 of those deaths involving prescription opioids. As the most populous state in the country, the raw number of individuals in California affected by improper prescribing and misuse is substantial, with rates varying significantly across counties, and even within counties. California's highest opioid overdose rates are in several rural northern California counties. For example, Lake and Shasta Counties have prescription opioid related death rates that are two to three times higher than the national average. San Francisco, Orange, and San Diego have higher than state average rates, accounting for a greater total number of deaths. For state and local data on opioid mortality, morbidity and prescribing rates, please visit the California Opioid Overdose Surveillance Dashboard at pdop.shinyapps.io/ODdash_v1/."

The Office of Statewide Health Planning & Development recently produced a report showing the increase in emergency room care resulting from heroin overdoses from 2012 to 2016 by age group. For 20-29 year olds, the number of ER visits increased from approximately 210 in 2012 to 412 in 2016. For 30-39 year olds, the number of visits increased from approximately 100 in 2012 to 209 in 2016.

The DPH website contains the following information: The magnitude of legal and illegal opioid usage and related negative consequences (e.g., addiction) is high in terms of health impact to California residents. However, there is wide variation across the counties within California with some counties having much higher rates than others. The most recently available California data (2014) indicates: 1) Prescription opioid related overdose deaths peaked in 2009 and have leveled off in the last two years; 2) Heroin related overdose deaths and ED visits have sharply increased since 2011 (54% and 52% respectively); and 3) The number of prescriptions filled per 1,000 residents has leveled off and the morphine milligram equivalent (MME) per resident per year has actually decreased. The decrease in MMEs may reflect a decrease in the number of pills per prescription.



Note: Counts not currently available for 2015 Mortality & Morbidity
Sources: Death - CDPH Vital Statistics Multiple Cause of Death Files;
ED Visits - Office of State Healthcare Planning and Development;
Prepared by: California Department of Public Health - Safe and Active Communities Branch.

The higher of the two dark lines represents Prescription Opioid Overdose Deaths, and the lower dark line represents Heroin Overdose Deaths. For a color-coded version of this graph, please see the online version of the agenda on Budget Subcommittee'1 website: http://abgt.assembly.ca.gov/sub1hearingagendas

The State of California is leveraging a multi-sector collaboration at both the state and local levels to build a comprehensive approach to address the Opioid Epidemic. The statewide overarching strategy includes five main components: 1) Safe Prescribing; 2) Access to Treatment; 3) Naloxone Distribution; 4) Public Education Campaign; and 5) Data Informed/Driven Interventions. Grants from the Centers for Disease Control and Prevention (CDC) - Prescription Drug Overdose Prevention (PDOP) for States (PfS) are the glue through which this multi-pronged initiative is united, aligned, and coordinated.

The Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup - In response to the national Opioid epidemic, the California Department of Public Health (CDPH) Director and state partners launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) in 2014 to share information and develop collaborative prevention strategies to curb prescription drug overdose deaths and addiction in California. Additionally, the Workgroup provides a platform for state entities working to address opioid overdose and addiction to improve coordination and expand joint efforts. Click here to visit the Workgroup website. The Prescription Drug Overdose Prevention (PDOP) Initiative funded by the CDC grants supports and facilitates the statewide Workgroup and four Taskforces.

Prescription Drug Overdose Prevention Initiative (PDOP) – In addition to supporting the work of the Statewide Workgroup and four Task Forces, PDOP staff engages with an

array of local and state partners working on the opioid overdose epidemic. Current PDOP Initiative activities include:

- Promoting the CDC and Medical Board of California Prescriber Guidelines and registration and use of California's Prescription Drug Monitoring Program – CURES;

- Providing education and support to health payers and providers on best institutional prescribing policies and practices;

- Conducting a "Policy" Environmental Scan to identify current laws, regulations, and policies that best address opioid overdose and addiction prevention;

- Contracting with the San Francisco Department of Public Health and Keck School of Pharmacy to develop Opioid Stewardship Curriculums to be rolled out in early April 2017 in three northern California counties: Humboldt, Lake, and Shasta. The curriculums will be utilized to train professionals to conduct "academic detailing" (or educational outreach) with prescribers (physicians, physician assistants, and nurse practitioners) and pharmacists on safe opioid prescribing practices;

- Providing co-funding (along with the California HealthCare Foundation) to support two Opioid Safety Coalitions (Also see Opioid Safety Coalition section below for recent Request for Application (RFA) to fund 8-10 coalitions starting in June 2017);

- Developing a statewide media education campaign for California patients and consumers; and,

- Providing data, technical assistance, and support to local health departments, coalitions, and community members in translating overdose and related data into actionable information to address the opioid prescription/illicit drug problem locally.

California Opioid Overdose Surveillance Dashboard – PDOP Initiative scientific staff has developed the California Opioid Overdose Surveillance Dashboard. The goal is to provide a data tool with enhanced data visualization and integration of statewide and geographically-specific non-fatal and fatal opioid-involved overdose and opioid prescription data. The dashboards and data available through the dashboard are the result of ongoing collaboration between the CDPH, Office of Statewide Health Planning and Development (OSHPD), Department of Justice (DOJ), and the California Health Care Foundation (CHCF). Since November 1, 2016, there have been 1,031 users, 15,673 page views, and 373 files have been downloaded from the dashboard.

Partner Initiatives - In addition to the CDC original and supplemental grants awarded to CDPH, two other grants were awarded to California state agency partners along with seventeen coalition grants awarded to local communities to address the opioid crisis in California. The first is a Harold Roger Grant awarded to the California Department of

Justice (DOJ) to upgrade the Prescription Drug Monitoring Program for the state. (DOJ sits on the Agenda Setting Team for the statewide Workgroup.) The second state agency grant is a Substance Abuse and Mental Health Services Administration (SAMSHA) grant recently awarded to the Department of Health Care Services (DHCS) – Substance Use Disorder Division. The grant focuses on infrastructure development and implementation of primary prevention strategies to address prescription drug misuse and abuse among youth. Finally, the California Health Care Foundation (CHCF) has awarded grants to seventeen local communities (in 24 counties) to create local opioid safety coalitions.

The California Department of Public Health/Safe and Active Communities Branch recently announced twelve awarded recipients for the Request for Applications - Local Coalitions to Address Opioid Misuse and Abuse. These awardees will be implementing comprehensive local opioid safety coalition activities beginning June 2017 through February 2019. The Awardees are:

- Health Improvement Partnership of Santa Cruz County
- Mendocino County Health and Human Services
- Siskiyou Community Services Council
- County of San Luis Obispo Behavioral Health Department
- San Diego County Medical Society
- L.A. Care Health Plan
- Sierra Sacramento Valley Medical Society
- Plumas County Public Health Agency
- California Health Collaborative
- Butte County Public Health Department
- Marin County Department of Health and Human Services
- Alameda-Contra Costa Medical Association Community Health Foundation

2016 Budget Act $3 million General Fund appropriation for Naloxone

DPH recently provided the Legislature with the following description of this funding and update on its implementation:

> "In support of statewide efforts to combat the growing number of opioid overdose deaths in California, the 2016-17 Budget allocated a total of $3 million on a one-time basis to the California Department of Public Health (CDPH) to support Naloxone distribution grants. The goal of the funding is to save lives by

distributing the drug naloxone to high risk communities across the state as quickly and efficiently as possible. Naloxone works by blocking opioid receptors in the brain, immediately reversing the effects of opioids including the respiratory depression, extreme drowsiness, slowed breathing, and loss of consciousness that can lead to death. Naloxone can be given by a non-medical bystander to a person experiencing an opioid overdose.

After discussions with the California Conference of Local Health Officers, interviews with 20 local health officers, and discussions with stakeholders, CDPH has determined that the most efficient way to distribute these funds is to purchase Narcan® (naloxone in a nasal spray) and offer each local health department (LHD) the opportunity to apply for an allocation of naloxone. Narcan® nasal spray will be purchased in bulk by CDPH at a negotiated rate of $75.00 per box of two doses.

On March 27, CDPH released a Request for Applications (RFA) directed at all 61 LHDs (the 58 counties and the cities of Berkeley, Pasadena and Long Beach). LHDs are the only eligible applicants at this time. Local Health Departments are in the best position to understand the needs of their communities and to distribute naloxone to organizations that can get it where it is needed most. All 61 LHDs will have the opportunity to acquire naloxone, but those with greatest need will receive more. Allocation amounts are based on county-level data on the number of opioid related overdose deaths and emergency room visits and according to an evidence-based distribution formula from the federal Centers for Disease Control and Prevention (CDC). LHDs may choose to receive limited funds (no more than 5% of the total award) to cover appropriate administrative costs.

In order to be eligible to receive naloxone, LHDs must first conduct outreach to and identify for distribution of naloxone entities within their health jurisdiction which regularly interact with persons at greatest risk of an opioid overdose, including entities that have a naloxone distribution system already in place. Priority will be given to Harm Reduction Programs. Harm Reduction Programs are focused on limiting the risks and harms associated with unsafe drug use, which is linked to serious adverse health consequences, including HIV transmission, viral hepatitis, and death from overdose. LHDs will report to CDPH data on distribution efforts and outcomes."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Waldron to present her proposal and requests DPH present an overview of this issue, the State's response, an update on the funding for Naloxone distribution included in the 2016 Budget Act, and any technical feedback they may have to the Assemblymember's proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: SUBSTANCE USE SERVICES AND WORKLOAD BUDGET CHANGE PROPOSAL

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

This issue provides background and updates on the provision of substance use disorder services through Medi-Cal, as well as the Administration's Budget Change Proposal requesting resources to address various workload increases within the Substance Use Disorder Services (SUDS) Division, as described below.

This proposal requests funding of 14.0 new permanent positions, conversion of 6.0 Limited Term (LT) positions to permanent and limited term funding equivalent to 8.0 LT positions. Total Funding Requested: Special Fund (SF) - Residential and Outpatient Program Licensing Fund (ROPLF) is $1,726,000 and Narcotic Treatment Program Licensing Trust Fund (NTPF) is $290,000; Federal Fund (FF) - Substance Abuse Prevention and Treatment (SAPT) Grant; and Reimbursement is $531,000.

BACKGROUND

In 2011, funding for the DMC program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS as part of the Public Safety Realignment initiated by AB 109 (Committee on Budget), Chapter 15, Statutes of 2011. Prior to the realignment of the DMC program, DMC was funded with General Fund and federal funds. Enactment of the 2011 Public Safety Realignment marked a significant shift in the state's role in administering programs and functions related to substance use disorders (SUD). Realignment also redirected funding for DMC and discretionary substance use disorder programs to the counties. Consequently, counties are responsible for providing the non-federal match used to draw down federal Medicaid funds for DMC services as they existed in 2011 and for individuals eligible for DMC under 2011 Medi-Cal eligibility rules (pre-health care reform). Additionally, the enactment of 2012-13 and 2013-14 state budgets transferred the responsibility for the SUD programs including DMC, from the former DADP to DHCS.

Current regulations create requirements for oversight of DMC providers at both the state and county levels. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for DMC services directly, or contract with DHCS, which then directly contracts with DMC providers to deliver DMC services. Counties that elect to contract with DHCS to provide DMC services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement. As of November 2013, DHCS contracts with 44 counties for DMC services. Another county has direct provider contracts thus resulting in DMC services being offered in 45 total counties. DHCS also has 15 direct provider contracts for DMC services in five counties (Imperial, Orange, San Diego, Solano, and Yuba-Sutter).

Health Care Reform Expansion of SUD Benefits

The federal Affordable Care Act (ACA) requires states electing to enact the Act's Medicaid expansion to provide all components of the "essential health benefits" (EHB) as defined within the state's chosen alternative benefit package to the Medicaid expansion population. The ACA included mental health and substance use disorder services as part of the EHB standard, and because California adopted the alternative benefit package it was required to cover such services for the expansion population.

SB 1 X1 (Hernandez and Steinberg), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, required Medi-Cal to provide the same mental health and substance use disorder services for its enrollees that they could receive if they bought a particular Kaiser small group health plan product designated in state law as the EHB benchmark plan for individual and small group health plan products. SB 1X 1 required this benefit expansion for both the expansion population and the pre-ACA Medi-Cal population. Consequently, those individuals previously and newly-eligible for Medi-Cal will have access to the same set of services.

For SUD-related services, SB 1 X1:

- Expanded residential substance use services to all populations (previously these benefits were only available to pregnant and postpartum women);

- Expanded intensive outpatient services to all populations (previously these benefits were only available to pregnant women and postpartum women and children and youth under 21); and

- Provided medically necessary voluntary inpatient detoxification (previously this benefit was covered only when medically necessary for physical health reasons).

DHCS received approval from CMS to expand intensive outpatient services to all populations and to provide medically necessary voluntary inpatient detoxification in general acute hospital settings. However, CMS asked the state to remove the expansion of residential substance use services to all populations and the provision of inpatient voluntary detoxification in other settings in its state plan amendment (SPA) because of the Institutions for Mental Disease (IMD) payment exclusion.

Medi-Cal Substance Use Disorder Services

Substance use disorder services are provided through both the Drug Medi-Cal program and also through Medi-Cal managed care and fee-for-service.

Drug Medi-Cal program services include:

- **Narcotic Treatment Services** – An outpatient service that utilizes methadone to help persons with opioid dependency and substance use disorder diagnoses detoxify and stabilize. This service includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.

- **Residential Treatment Services** – These services provide rehabilitation services to persons with substance use disorder diagnosis in a non-institutional, non-medical residential setting. (Room and board is not reimbursed through the Medi-Cal program.) Prior to SB 1 X1, this benefit was only available to pregnant and postpartum women.

- **Outpatient Drug Free Treatment Services** – These outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Services include individual and group counseling, crisis intervention, and treatment planning.

- **Intensive Outpatient Treatment Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week. Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women and children and youth under 21.

Other Medi-Cal SUD benefits, that are not included in DMC, include:

- **Medication-Assisted Treatment** – This service includes medications (e.g., buprenorphine and Vivitrol) that are intended for use in medication-assisted treatment of substance use disorders in outpatient settings. These medications are provided via Medi-Cal managed care or Medi-Cal FFS, depending on the medication.

- **Medically Necessary Voluntary Inpatient Detoxification** – This service includes medically necessary voluntary inpatient detoxification and is available to the general population. This service is provided via Medi-Cal FFS.

- **Screening and Brief Intervention** – This service is available to the Medi-Cal adult population for alcohol misuse, and if threshold levels indicate, a brief intervention is covered. This service is provided in primary care settings. This service is provided via Medi-Cal managed care or Medi-Cal FFS, depending on which delivery system the patient is enrolled.

Drug Medi-Cal Waiver

DHCS has received CMS approval for a DMC Organized Delivery System Waiver. DHCS states that this waiver will give state and county officials more authority to select quality providers to meet drug treatment needs. DHCS indicates the waiver will support coordination and integration across systems, increase monitoring of provider delivery of services, and strengthen county oversight of network adequacy, service access, and standardize practices in provider selection.

Key elements of the new waiver include:

- **Continuum of Care:** Participating counties will be required to provide a continuum of care of services available to address substance use, including: early intervention, physician consultation, outpatient treatment, case management, medication assisted treatment, recovery services, recovery residence, withdrawal management, and residential treatment.

- **Assessment Tool:** Establishing the American Society of Addiction Medicine (ASAM) assessment tool to determine the most appropriate level of care so that clients can enter the system at the appropriate level and step up or step down in intensive services, based on their response to treatment.

- **Case Management and Residency:** Case management services to ensure that the client is moving through the continuum of care, and requiring counties to coordinate care for those residing within the county.

- **Selective Provider Contracting:** Giving counties more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access.

- **Provider Appeals Process:** Creating a provider contract appeal process where providers can appeal to the county and then the State. State appeals will focus solely on ensuring network adequacy.

- **Provider Certification:** Partnering with counties to certify DMC providers, with counties conducting application reviews and on-site reviews and issuing provisional certification, and the State cross-checking the provider against its databases for final approval.

- **Clear State and County Roles:** Counties will be responsible for oversight and monitoring of providers as specified in their county contract.

- **Coordination:** Supporting coordination and integration across systems, such as requiring counties enter into memoranda of understanding (MOUs) with Medi-Cal managed care health plans for referrals and coordination and that county substance use programs collaborate with criminal justice partners.

- **Authorization and Utilization Management:** Providing that counties authorize services and ensuring Utilization Management.

- **Workforce:** Expanding the pool of Medi-Cal eligible service providers to include licensed practitioners of the healing arts for the assessment of beneficiaries, and other services within their scope of practice.

- **Program Improvement:** Promoting consumer-focused evidence-based practices including medication-assisted treatment services and increasing system capacity for youth services.

This waiver will only be operational in counties that elect to opt into this organized delivery system. DHCS states that the early phases are considered demonstration projects but the goal is for the model to eventually be implemented statewide. Counties that opt into this waiver will be required to meet specified requirements, including implementing selective provider contracting (selecting which providers participate in the program), providing all DMC benefits, monitoring providers based on performance criteria, ensuring beneficiary access to services and an adequate provider network, using a single-point of access for beneficiary assessment and service referrals, and data collection and reporting. In a county that does not opt-in, there will be no change in services from the current delivery system.

According to DHCS, six counties are expected to begin providing services under the DMC-ODS Waiver in 2016-17: San Mateo, Santa Cruz, Riverside, Santa Clara, Marin, and San Francisco. An additional ten counties are expected to begin providing services in 2017-18. The Department reports a total of 20 counties, representing approximately 73 percent of the state's population, are participating or planning to participate in the DMC-ODS Waiver. DHCS expects additional counties to opt in over the coming months.

The *County Behavioral Health Directors Association of California* Submitted a letter to the Subcommittee raising the following concern with regard to the implementation of the Waiver:

> "The pilot program requires counties that opt in to the demonstration program to provide a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services. A total of 6 counties are estimated to begin providing services in 2016-17, with an additional 10 counties in 2017-18. In addition to the expanded residential and intensive outpatient SUD services, ODS opt-in counties will also provide access to case management, recovery support services, and enhanced medication assisted treatment for all eligible beneficiaries. Under the Governor's Budget proposal, counties will only be able to claim SGF for the non-perinatal residential and intensive outpatient services. We would encourage the Legislature to add language authorizing the use of the SGF contribution to cover the non-federal share of cost for the other ODS expansion services as well."

Drug Medi-Cal Program Integrity

In July 2013, an investigation by the Center for Investigative Reporting (CIR) and CNN uncovered allegations of widespread fraud in California's Drug Medi-Cal (DMC) program. Most of the examples of alleged fraud occurred in Los Angeles County and ranged from incentivizing patients with cash, food, or cigarettes to attend sessions, to billing for clients who were either in prison or dead. Most of the providers that were the focus of the investigation primarily offered counseling services and rely on Medi-Cal as the sole payer for services. The reports suggested that the State's oversight and enforcement bodies were not working well in tandem: county audits of providers identified a number of serious deficiencies, but failed to terminate contracts or prevent the problems from continuing.

Budget Change Proposal

DHCS, Substance Use Disorder - Compliance Division (SUDCD), requests staff resources and associated expenditure authority to address increased workload and to carry out new and existing state and federal requirements for the expansion of services from the Affordable Care Act (ACA) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.

Specifically, the resources will build upon the existing infrastructure to:

1. reduce the application and complaint backlogs and conduct initial and renewal monitoring visits;
2. provide state level guidance and innovations in DMC-ODS Waiver opt-in counties to combat the opioid epidemic in California;
3. enact the federal requirements to designate and monitor facilities according to the American Society of Addiction Medicine (ASAM) levels;
4. address requirements to effectively regulate alcohol and other drug (AOD) treatment facilities; and
5. address the licensing and monitoring functions specific to Los Angeles (LA) County facilities.

This proposal requests funding of 14.0 new permanent positions, conversion of 6.0 Limited Term (LT) positions to permanent and limited term funding equivalent to 8.0 LT positions. Total Funding Requested: Special Fund (SF) - Residential and Outpatient Program Licensing Fund (ROPLF) is $1,726,000 and Narcotic Treatment Program Licensing Trust Fund (NTPF) is $290,000; Federal Fund (FF) - Substance Abuse Prevention and Treatment (SAPT) Grant; and Reimbursement is $531,000.

The ACA increased the proportion of criminal justice involved individuals eligible for health care coverage specifically those with a Substance Use Disorder (SUD). ACA parity protections require that coverage for SUD services be no more restrictive than coverage, provided for substantially all medical/surgical services. In anticipation of meeting increased demand for services due to healthcare reform, DHCS has identified current gaps in the existing system. DHCS has addressed some of the identified gaps with the approval and implementation of the DMC-ODS Waiver, which expands substance use disorder services. In addition, with the passage of Assembly Bill 848

(Stone, Chapter 744, Statutes of 2015), incidental medical services are available within the residential treatment programs and increase the care afforded to clients. With the expansion of government and nongovernment funded services due to state and national efforts, it requires an increase in licensing and monitoring activity across all treatment modalities.

DHCS states that it is seeing a substantial growth trend in facilities seeking licensure, and estimates that this growth will continue over the next several years. As a part of the 2013-2014 Budget, the Department of Alcohol and Drug Programs (and all SUDCD services) transferred to DHCS on July 01, 2013. SUDCD is made up of four sections; Licensing & Certification Section (LCS), Narcotic Treatment Program Section (NTPS), Complaints Section (CS) and Driving-Under-the-Influence & Criminal Justice Section (DUI-CJS).

Licensing and Certification Section (LCS)
LCS has sole authority in state government to license and certify all facilities, regardless of their funding source, that provide 24-hour residential and outpatient alcohol and other drug (AOD) treatment, detoxification, or recovery services to adults. LCS is responsible for processing initial and renewal applications for residential, outpatient, detoxification, adolescent waivers, incidental medical services, and ASAM designations and for conducting site visits for each initial and renewal. LCS is also responsible for monitoring compliance with state, federal and local laws, regulations and statutes by conducting reviews every two years. LCS is currently implementing the ASAM Designation process, which includes the provisional and final Level 3.1, 3.3 and/or 3.5 designation, collecting fees and fines, and providing technical assistance to facilities assisting individuals in need of recovery or treatment services. DHCS currently certifies 1,777 licensed and/or certified facilities - 356 residential, 560 residential/AOD, and 861 AOD outpatient.

Chapter 177 (Senate Bill 84), Statutes of 2007, Health and Safety Code (HSC) Section 11833.02 was signed into law on August 24, 2007, and requires DHCS to charge fees for licensure and certification of all residential AOD recovery or treatment facilities and for certification of outpatient AOD programs. The ROPLF consists of all fines, fees, and penalties assessed to licensed and certified AOD providers. HSC Section 11833.03 establishes the ROPLF in the State Treasury into which all fees, fines, and penalties collected from residential and outpatient programs, which are deposited and made available upon appropriation by the Legislature for supporting the licensing and certification activities of residential and outpatient facilities.

Narcotic Treatment Programs (NTP) Section
The NTP Section is responsible for the statutory and regulatory compliance of all NTPs in California through mandated annual on-site inspections. The NTP Section responsibilities include the review of initial licensure and annual renewal applications, follow-up on-site inspections for programs that present imminent danger to patients, administrative functions such as grant and contract management, facility complaint investigations, patient death investigations, the monitoring of requests for exceptions to regulations through the Center for Substance Abuse Treatment extranet, and providing technical assistance for the submission of various protocol amendments and capacity changes.

With the implementation of the DMC-ODS Waiver, there is the requirement for counties opting to participate to include NTP services. Of the 53 counties that have expressed interest in participating in the DMC-ODS Waiver, 24 currently do not provide NTP services. This has resulted in comprehensive efforts to work with counties and NTPs to license new facilities and expand medication-assisted treatment (MAT) services in these counties. Additionally, Drug Medi-Cal does not cover four new MAT medications which are required under the DMC-ODS Waiver. This has added the need to designate staff resources to establish new regulations, policies and procedures, on-site inspection tools, and subsequent extension of on-site monitoring processes.

DHCS SUDCD additionally has the sole authority to determine the appropriate skills and qualifications of an individual providing AOD counseling to clients in licensed residential and/or certified facilities, licensed NTPs, programs certified to receive Medi-Cal reimbursement and licensed DUI programs. California Code of Regulations stipulate that all individuals providing AOD counseling in any of the identified programs or facilities must be registered, certified or licensed pursuant to Title 9, Chapter 8. The regulatory requirements were developed to safeguard the health and safety of the population served and to maintain minimum AOD counselor education standards regardless of modality or geographic area.

Complaints Section (CS)
CS is responsible for investigating complaints brought against licensed residential treatment programs, outpatient programs and unlicensed programs. CS is also responsible for investigating all complaints brought against registered or certified counselors who are employed by a SUDCD program. CS investigates unusual incidents that occur at SUDCD locations, up to and including client deaths. Since securing the 6.0 LT positions in the FY 2014-2015 Substance Use Disorder Program Integrity BCP, CS has received 261 unlicensed complaint investigations, 222 counselor investigations, 76 death investigations and 593 general complaint investigations for a total of 1,152 investigations.

Pursuant to the Public Records Act, (PRA, government code section 6250 et seq.) the public has a right to inspect and/or obtain copies of any SUDCD investigations. CS works closely with the DUI-CJS to process PRA requests on a daily basis, which involves the retrieval of pertinent files, review and redaction of documents, which contain confidential and protected information as well as personal health information, including medical records, pending litigation documents, and other records containing private information about individuals. This process takes extensive coordination with other DHCS divisions to secure compliance with all applicable PRA requirements. DHCS may need to review requested records to determine if an exemption applies before a record is inspected or copied.

SUDCD is responsible for investigating and taking action against AOD facilities operating outside the scope of their licensure. Once SUDCD determines a facility is in violation of the law, an action must be taken against non-compliant facilities including the revocation or suspension of these licenses. The process for revocation is detailed and requires more Personnel Year (PY) hours to complete than other investigations.

Even when a facility is known to have been providing unsafe services, the facility has the right to appeal DHCS' decision and may still operate until the revocation is complete. On average, one revocation alone takes over eight months to complete. With the assistance provided by the 6.0 LT positions, SUDCD CS has uncovered five separate causes for revocation within the past three years, two of which are currently set for hearing.

The new government and private health insurance funding sources available for SUD treatment are resulting in a substantially expanding the number of facilities requiring DHCS licensing and oversight. With system expansion and multiple funding streams available to providers, mitigation of fraudulent activity remains a top priority for SUDCD and appropriate staffing levels will greatly assist in this endeavor.

While DHCS is committed to Californians that require and utilize services provided by residential rehabilitation programs, outpatient programs and narcotic treatment programs, due to the increased focus on the SUD field, the SUDCD cannot sustain the substantial increase in licensing workload. There are backlogs of new applications, applications for expansion of current facilities, license and certification renewals that are not meeting the mandated timelines outlined in Statute, applications for new service designations such as the American Society of Addiction Medicine (ASAM), and facility complaints. These backlogs can delay the expansion of treatment services for new clients and potentially puts current clients at risk if there is not proper monitoring at the state level.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Drug Medi-Cal program, the new waiver, this Budget Change Proposal and any significant changes, developments and updates to the financing of SUD services. Please also respond to the following:

1. Please respond to the concern raised by the County Behavioral Health Directors Association described above regarding the implementation of the Waiver.

2. Please explain recent developments with regard to the participation of Central Valley counties in the Waiver.

Staff Recommendation: Subcommittee staff recommends no action at this time.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 3: SUICIDE PREVENTION OVERSIGHT AND STAKEHOLDER PROPOSAL

PANEL 1: EXPERTS

- **Rebecca Anne Bernert**, PhD, Assistant Professor, Stanford University
- **Anara Guard**, Public Health Consultant
- **Theresa Ly**, MPH, Program Manager, California Mental Health Services Authority (CalMHSA)
- **Lyn Morris**, MFT, Senior Vice President, Clinical Operations, Didi Hirsch Mental Health Services

PANEL 2: ADMINISTRATION & LAO

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE AND PROPOSAL

The purpose of this oversight issue is to gain a better understanding of suicide in California and what is known about effective prevention strategies. The Subcommittee would like to become more familiar with suicide statistics such as rates by various demographics (age, race, ethnicity, sexual and gender orientation, veteran status, etc.) and rates by methods of suicide. Finally, by learning more about the latest research on prevention strategies, the Subcommittee hopes to be able to evaluate funding requests in this area more effectively and encourage the state to provide leadership and to make a financial investment in this area in order to address this problem effectively.

- In 2014, the Legislature approved of $7 million (Proposition 63 State Administration funds) to provide the final component of funding needed to build a suicide deterrent system for the Golden Gate Bridge. The total cost of this project is projected to be $2014,195,000 and the Golden Gate Bridge District has

received authorization from CalTrans to proceed with the project. The District awarded the construction contract and expects construction to begin during the spring of 2017. The project is expected to take four years to complete.

- In 2016 the Legislature approved and the final budget includes $4 million (Proposition 63 State Administration funds) for suicide hotlines, to replace funding formerly provided by the California Mental Health Services Authority (CalMHSA) with county Proposition 63 dollars. Community based organizations are proposing to extend this $4 million for an additional year in the absence of a long-term funding plan for suicide hotlines.

- An Office of Suicide Prevention operated within the former Department of Mental Health however when the DMH was eliminated, and community mental health services were moved to DHCS, this Office was effectively disbanded.

STAKEHOLDER PROPOSAL

Community mental health advocates request $4 million for suicide hotlines in order to continue the services and enhancements that potentially will be made possible by $4 million (MHSA/Prop 63 Fund) included in the 2016 Budget Act, subject to sufficient funding in the MHSA State Admin cap.

Advocates assert that the eleven crisis centers in California that answer calls through the National Suicide Prevention Lifeline network have no stable funding. Yet, the Lifeline is advertised by health insurers, federal/state/county health and mental health agencies, schools and universities, and private practitioners.

Although the federal Substance Abuse and Mental Health Services Administration (SAMSHA) funded the launch of Lifeline, and funds the agency coordinating Lifeline operations— such as linking technology, data collection and best practices--it provides no other long-term financial support to the local agencies that operate it, other than annual stipends of $1,000 to $3,000.

Five years ago, California's counties agreed to pool some Mental Health Services Act (MHSA/Proposition 63) funds for three initiatives: school mental health, stigma reduction and suicide prevention. In 2012, this funding helped establish new crisis lines; develop common crisis line metrics and best practices; add services in Korean and Vietnamese; and support agencies that had been answering Lifeline calls without reimbursement. This funding for suicide prevention, however, ended on July 1, 2015 when many counties declined to renew, or reduced, the percentage of MHSA funds they would contribute. Advocates state that the loss of MHSA funding has resulted in:

- withdrawal of crisis lines from the Common Metrics project;
- some counties no longer receiving services;
- the ending of a best practices initiative; and
- only one center provides full-time services in Spanish made possible by its own county doubling its financial support.

Advocates for this proposal provided the following information:

> "In 2014, the U.S. lost 42,773 children and adults to suicide—a toll that exceeded the number of Americans lost to car accidents or AIDS. Suicide is the 2nd leading cause of death among 15-24 year-olds. For every death, there are about 25 individuals who survive suicide attempts, which increases their risk of eventual suicide.
>
> In 2014, medical costs alone were over $350 million to provide medical care to approximately 50,000 Californians after a suicide attempt and $17 million to provide medical care to 4,214 Californians who died by suicide.
>
> Residents in every county in California call the National Suicide Prevention Lifeline (Lifeline) number. Launched by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2005, the network has expanded considerably over the years. Now receiving 1.5 million calls annually, the Lifeline network provides 24-7 Spanish coverage, a Veteran's line, crisis chat, follow-up services and a Disaster Distress Helpline."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the panel of experts to share California-specific data on suicide rates, trends, demographics and any other information to help the Legislature understand suicide in California. The expert panel also is requested to share research on the effectiveness of various prevention strategies, innovative approaches that are, or could be, underway in California, and respond to the following:

1. What are the most common methods of suicide used in California?

2. What is known about the effectiveness of bridge nets (deterrent systems), such as the one that will be added to the Golden Gate Bridge?

3. What evidence is there supporting the effectiveness of suicide hotlines, particularly as compared to strategies that make use of newer technology?

4. How would you recommend California invest in suicide prevention?

The Subcommittee requests DHCS and the Commission to provide reactions and thoughts about the state's role in suicide prevention, and respond to the following?

1. Has DOF determined the availability of the $4 million MHSA State Admin funding included in the 2016 Budget Act for suicide hotlines?

2. Why was the Office of Suicide Prevention disbanded with the elimination of the Department of Mental Health?

3. Would you like to see the state provide leadership on suicide prevention?

Staff Recommendation: Subcommittee staff recommends adoption of placeholder supplemental reporting language that requests the Commission to develop a suicide prevention strategic plan for California.

If you or someone you know is in crisis, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). (Not DHCS)

Si usted o alguien que usted conoce esta en una crisis por favor llame a la Red para la Prevención del Suicidio al 1-888-628-9454. (Not DHCS)

ISSUE 4: PROPOSITION 63 FISCAL REVERSIONS

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

OVERSIGHT ISSUE

The Mental Health Services Act (MHSA/Proposition 63) requires county unspent funds to revert to the state to then be redistributed to counties. Many counties are holding unspent funds as there have been no reversions of these funds since 2008, creating legal and policy challenges for the counties and state.

BACKGROUND

In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directed the majority of revenues to county mental health programs and services in the following five categories:

1. Community Services and Supports (CSS): 80 percent of county MHSA funding treats severely mentally ill Californians through a variety of programs and services, including full service partnerships and outreach and engagement activities aimed at reaching unserved populations.

2. Prevention and Early Intervention (PEI): Up to 20 percent of county MHSA funds may be used for PEI programs, which are designed to identify early mental illness, improve timely access to services for underserved populations, and reduce negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.

3. Innovation: Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Since 2008-09, counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:

4. Workforce Education and Training: This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

5. Capital Facilities and Technological Needs: This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental illness in the county. Adjustments are made for the cost of living and other available funding resources. The formula also provides a minimum allocation to rural counties for the CSS and PEI components.

Reversion Requirements for Unspent County Funds. MHSA requires the reversion of unspent county funds to the state. According to Welfare and Institutions Code section 5892 (h), "any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years". However, DHCS has not reverted unspent county funds since 2008.

Concerns About Reversion Policies. Mental health advocates have expressed concerns that counties are retaining MHSA funds that could be reverted and reallocated to the provision of additional mental health services. However, counties have reported various challenges with accurate reporting of funds subject to reversion, including limitations on reporting forms from DHCS, inadequate identification of funds owed, and unclear policies for reversion.

Commission Recommendations. In March 2017, the Commission released a discussion draft for consideration by Commission members titled Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities. The draft identified many of the long-standing issues preventing appropriate reversion of unspent MHSA funds and made several recommendations for the Commission, DHCS and the Legislature. These included:

1. "Reset" Reversion Policies – the Commission recommended DHCS continue to update its fiscal reporting requirements to take effect in 2017-18 and beyond. For prior years, the Commission recommends three options for the Legislature to consider regarding the identification, reporting or reversion of unspent MHSA funds:

    - Hold counties harmless for reversion prior to 2017-18
    - Allow counties to retain a portion of reverted funds
    - Hold counties harmless for reversion prior to 2012-13, when responsibilities were transferred from the former Department of Mental Health to DHCS.

2. Extend Reversion Period from Three to Five Years for Small Counties – Because small counties experience greater challenges in funding and sustaining mental health services programs with limited MHSA allocations, the Commission recommends the Legislature allow small counties to apply for state approval to extend the reversion timeline for funds subject to the three-year limit.

3. Allow Counties to Revise Annual Revenue and Expenditure Reports – the Commission recommends DHCS clarify whether and how counties may amend their annual revenue and expenditure reports with updated, more complete, or audited information.

4. Establish an MHSA Reversion Fund – the Commission recommends establishing an MHSA Reversion Fund to receive unspent county MHSA funds. This fund would highlight the level of unspent funds reverted to the state, enhance incentives for counties to spend MHSA allocations, and allow the Legislature to reallocate this funding to unmet mental health services needs in the state.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission to provide an overview of this issue, and for the Commission and DHCS to respond to the following:

1. DHCS: Please describe the challenges that have led to the extensive delay in fiscal reversion of MHSA funds.
2. DHCS: What is the current plan, if any, and expected timeframe for reversion of unspent MHSA funds?
3. DHCS: What is the status of the requirement from AB 1618, Chapter 43, Statutes of 2016 that requires DHCS to post the three-year program and expenditure plans submitted by every county?
4. Commission: Please describe the recommendations in your discussion draft: "Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities".
5. Commission and DHCS: What is the scope of unspent funds statewide that might be available for reversion and reallocation? How would the reallocation occur?

Staff Recommendation: Subcommittee staff recommends no action at this time.

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

ISSUE 5: 2016 FUNDING FOR CHILDREN'S MENTAL HEALTH CRISIS SERVICES AND COMMUNITY INFRASTRUCTURE GRANTS

PANEL

- California Health Facilities Financing Authority
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Governor's proposed January budget eliminates funding for two programs included in the 2016 Budget Act that were legislative initiatives as follows:

1. Elimination of Community Infrastructure Grants—The Budget includes the reversion of the one-time $67.5 million General Fund augmentation included in the 2016 Budget Act for community infrastructure grants to cities and/or counties to promote public safety diversion programs and services by increasing the number of treatment facilities for mental health, substance use disorder, and trauma-related services.

2. Children's Mental Health Crisis Services Grants—The Budget includes the reversion of $17 million General Fund from 2016-17 funds intended for grants to local governments to increase the number of facilities providing mental health crisis services for children and youth under the age of 21. Nearly $11 million in Mental Health Services Act funding remains available for the program

BACKGROUND

Elimination of Community Infrastructure Grants

The 2016 Budget Act includes $67.5 million General funds and trailer bill (Welfare and Institutions Code Section 5848.51) to establish a competitive grant program designed to promote diversion programs and services by increasing and expanding mental health treatment facilities, substance use disorder treatment facilities, and trauma-centered service facilities, including facilities providing services for sex trafficking victims, domestic violence victims, and victims of other violent crimes, in local communities, through the provision of infrastructure grants.

Grant awards made by CHFFA were to be used to expand local resources for facility acquisition or renovation, equipment acquisition, and applicable program startup or expansion costs to increase availability to, and capacity of, diversion programs.

Children's Mental Health Crisis Services Grants

Researchers and advocates have called attention to the long-term problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited mental health services for individuals, children in particular, in psychological distress and acute psychiatric crisis. Nearly 40,000 California children ages 5-19 (or five of every 1,000) were hospitalized for mental health issues in 2014.

In 2015, the Mental Health Services Oversight and Accountability Commission (Commission) initiated a project to understand the state of children's mental health crisis services, document challenges, identify effective service delivery models, and advance specific policy, funding, and regulatory changes to improve service quality and outcomes. According to a draft Commission report, "no county has successfully built out the full continuum of services required to fully meet the needs of children and families in crisis." The Commission has issued draft recommendations to "support the continued buildout" of a comprehensive continuum of crisis services and ensure access for all children and youth.

Research further indicates that crisis residential and stabilization programs reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of emergency room visits, and divert inappropriate incarcerations while producing the same or superior outcomes to those of institutional care. Furthermore, these types of services, according to a California Mental Health Planning Council report, exemplify "the spirit, intent, and guidelines of the Mental Health Services Act" in that it "is a recovery-oriented, client-driven system that modifies to the needs of the client for optimal outcomes."

The continuum of children's crisis services includes:

- Crisis Residential – Crisis residential programs are a community-based treatment option in home-like settings that offer safe, trauma informed alternatives to psychiatric emergency units or other locked facilities.

- Crisis Stabilization – Crisis stabilization services are those lasting less than 24 hours for individuals who are in psychiatric crisis. The goal of crisis stabilization is to avoid the need for inpatient services. These services must be provided on a site at licensed 24-hour health care facility.

- Mobile Crisis Support Teams – Mobile crisis support teams can provide crisis intervention and family support.

- Family Support Services – Family support services help families participate in the planning process, access services, and navigate programs.

In order to create a mental health crisis continuum of care for children, the 2016 Budget Act includes the following funding:

CHFFA Funding:

- $10 million General Fund one-time
- $6 million General Fund reappropriation
- $11 million Mental Health Services Act State Administration Funds one-time

Commission Funding:

- $3 million Mental Health Services Act State Administration Funds one-time

The Governor's budget proposes to eliminate $17 million in General Fund from CHFFA which includes the following: 1) $10 million General Fund included in the 2016 Budget Act; 2) $6 million General Fund reappropriation (from SB 82 funding) included in the 2016 Budget Act; and 3) $1 million in SB 82 reversion funds from counties that have gone unspent for SB 82 purposes and therefore have reverted to the State.

SB 82 Reversions

It is unclear exactly where the $1 million in reverted SB 82 funding is coming from. The SB 82 statute gives counties until June 30, 2016 to use or lose their SB 82 funding, and therefore it is unclear why these funds would have reverted to the state already. Moreover, counties have submitted letters to the Subcommittee requesting an extension to the availability of SB 82 funds, from the current deadline of June 30, 2016 until December 31, 2021. Counties state that it has been very challenging to site crisis residential and stabilization programs in residential areas due to "NIMBY" attitudes and zoning policies, thereby delaying the use of these funds. They also point to the significant time (several months) it can take to get approval from county boards of supervisors. Finally, counties state that a 9-month timeline for ground-up construction is a major challenge due to extensive federal, state and local laws and regulations that must be followed.

STAFF COMMENTS/QUESTIONS

It seems more than likely that both of the purposes for which funding is being eliminated would result in long-term savings for the State. The children's mental health crisis services are designed specifically for the purpose of reducing inappropriate and unnecessary emergency room use in favor of care that both costs less and is more effective. Similarly, the community infrastructure grants were intended to fund services that encourage diversion from incarceration, the most expensive and least-preferred response from the State. Eliminating this funding will increase state costs by continuing to institutionalize very vulnerable people, rather than investing in prevention and appropriate health care.

Subcommittee staff requests the Administration to present these two proposals to eliminate 2016 funding for community infrastructure grants and children's mental health crisis services, and respond to the following:

1. Where exactly has the additional $1 million in SB 82 reversion funds come from that is proposed for elimination from the children's mental health crisis funding?

2. Please respond to counties' request to extend the encumbrance period for SB 82 funding.

Staff Recommendation: Subcommittee staff recommends denying the Governor's proposals to eliminate funding for both community infrastructure grants and children's mental health crisis services grants.

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 6: COMMISSION OVERVIEW AND BUDGET

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Mental Health Services Oversight & Accountability Commission (Commission) proposed 2017-18 budget is $67.1 million, an $11.2 million (16.7%) decrease from current year funding. Nearly all of the funding for the Commission is Proposition 63 (Mental Health Services Act) state administration funding. The substantial (16.7%) decrease in funding from the current year to the proposed budget year does not reflect any policy changes, but rather reflects the phasing in of the triage grants program (SB 82), which resulted in the need to re-appropriate a larger amount of funding from prior years into the 2015-16 and 2016-17 budgets than into the 2017-18 budget.

Commission Budget

	2015-16 Actual	2016-17 Estimated	2017-18 Proposed
Total MHSA Funds	$48,002,000	$78,344,000	$67,146,000
Positions	26.2	26.2	29.2

BACKGROUND

Mental Health Services Act (Proposition 63, Statutes of 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. These tax receipts are reconciled and deposited into the MHSA Fund on a "cash basis" (cash transfers) to reflect funds actually received in the fiscal year. The MHSA provides for a continuous appropriation of funds for local assistance.

The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Most of the act's funding is to be expended by county mental health departments for mental health services consistent with their local plans (three-year plans with annual updates) and with the following required five components contained in the MHSA:

- **Community Services and Supports for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through its stakeholder process, a listing of programs for which these funds would be used. Of total annual revenues, 80 percent is allocated to this component.

- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.

- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded with five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.

- **Workforce Education and Training.** This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

Mental Health Services Oversight and Accountability Commission. The Mental Health Services Oversight and Accountability Commission (Commission) was established in 2005 and is composed of 16 voting members. These members include:

Elected Officials:

- Attorney General
- Superintendent of Public Instruction
- Senator selected by the President pro Tem
- Assemblymember selected by the Speaker

12 members appointed by the Governor:

- Two persons with a severe mental illness
- A family member of an adult or senior with a severe mental illness
- A family member of a child who has or has had a severe mental illness
- A physician specializing in alcohol and drug treatment
- A mental health professional
- A county sheriff
- A superintendent of a school district
- A representative of a labor organization
- A representative of an employer with less than 500 employees
- A representative of an employer with more than 500 employees
- A representative of a health care services plan or insurer

In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

Among other responsibilities, the role of the MHSOAC is to:

- Ensure that services provided, pursuant to the MHSA, are cost effective and provided in accordance with best practices;

- Ensure that the perspective and participation of members and others with severe mental illness and their family members are significant factors in all of its decisions and recommendations; and,

- Recommend policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the MHSA.

***Overview of MHSOAC Evaluation Efforts*.** On March 28, 2013 the Commission approved an Evaluation Master Plan which prioritizes possibilities for evaluation investments and activities over a five year course of action. The Commission five-year Evaluation Master Plan (July 2013 – June 2018) describes seven activities related to performance monitoring, ten evaluation projects, and eight exploratory/developmental work efforts. The 2013 budget provided resources for six positions to implement the Evaluation Master Plan. There are also many other entities engaged in MHSA evaluation projects, including by counties.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission provide an overview of the Commission, its work, and proposed budget, and respond to the following:

1. Please provide an update on the evaluation Master Plan and any other evaluations underway or completed on the MHSA.

2. How does the Commission ensure that counties are spending their MHSA funds appropriately and effectively?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 7: PREVENTION AND EARLY INTERVENTION PLAN REVIEWS BUDGET CHANGE PROPOSAL

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Mental Health Services Oversight and Accountability Commission (Commission) is requesting two positions and $309,000 additional ongoing personnel funds. AB 82 mandated the Commission to promulgate and implement regulations for Prevention and Early Intervention Programs (PEI) and Innovation Programs (INN).

BACKGROUND

AB 82 (Assembly Budget Committee, Chapter 23, Statutes of 2013) modified the Mental Health Services Act (MHSA) and directed the Commission to issue regulations for Prevention and Early Intervention Programs and Innovation Programs that were initially authorized under Proposition 63.

For this first phase of regulatory work, the Commission redirected administrative, program and legal staff for the development, review and adoption of regulations. The Commission absorbed this workload by delaying other work, reducing in the short term its commitments in some areas, such as plan review, contract monitoring and recruitment. In the summer of 2015, the Commission adopted regulations governing county implementation of Prevention and Early Intervention Programs and Innovation Programs.

For the second phase of its obligations under AB 82, the Commission is directed to monitor implementation of the regulations and to provide technical assistance to counties under both Prevention and Early Intervention Programs and Innovation Programs. This obligation includes the receipt, processing, analysis, and dissemination of findings from required county data and evaluation reporting elements. The regulations require counties, for the first time, to provide significant, program-level participant, outcome, and evaluation data for each PEI program on an annual basis. This creates a significant, new workload for the Commission to provide technical

assistance to the counties regarding the design and implementation of their data collection and reporting strategies, as well as opportunities for the Commission to conduct statewide oversight and evaluation of PEI programming. As of June 2016, there were approximately 616 ongoing county-level PEI programs.

The Commission has been actively engaged with the counties in developing a technical assistance agenda for implementation of the regulations. During February-June 2016, the Commission held four regional meetings to identify strategies for helping the counties implement the regulations successfully. The draft recommendations, not yet adopted by the Commission, include both development of technical assistance materials and facilitation of regular "learning collaborative" meetings with representatives from clusters of counties and providers to develop shared understandings of best practices for implementation. This implementation project has been conducted by temporarily redirecting staff from other areas, including legal, plan review, contract monitoring and other activities.

In the FY 2016-17 Budget, the Commission received funding for three positions to address the Innovation Programs (INN) component of the new workload created under AB 82—two Health Program Specialist I/II positions and one Research Program Specialist I/II position. The Commission is in the process of recruiting for these positions.

The Commission is requesting two additional positions—one Health Program Specialist I/II position and one Associate Governmental Program Analyst position—to address the PEI-related workload created under AB 82. The Commission has deployed 1.5 existing positions—a Consulting Psychologist and 0.5 of an existing Health Program Manager II—to support the work of both the PEI and INN units. Further, the Commission has dedicated, on an ad hoc basis, two existing Health Program Specialist I positions and an existing AGFA position to support implementation of the PEI and INN regulations.

The Commission anticipates an increase in requests for technical assistance relating to county PEI program and INN project spending, in part because the Commission is working to improve public awareness about county programming through the use of a Fiscal Transparency Tool and searchable program and project inventory tool on their website. The Fiscal Transparency Tool will allow the public, policymakers and mental health advocates to explore county utilization of MHSA funds and determine the availability of unallocated funds by component. The Commission anticipates that the tool will be live on their website before the end of April 2017. The searchable program and project inventory tool will allow the public, policymakers and mental health advocates to explore county MHSA activities at the program and provider levels to better understand how counties are prioritizing their MHSA expenditures. The Commission states that populating and maintaining the database of programs and providers will place a substantial workload on their plan review unit, most of which currently is redirected to support other PEI and INN program functions.

Providing Strategic Guidance. The Commission currently receives requests from counties for technical assistance and advice regarding INN and PEI programming. Individual counties, in consultation with local stakeholders, determine how best to allocate MHSA funds. While many counties are making strategic investments in

Innovation and PEI, the counties are not collectively strategic. As a result, the counties forego the opportunity to jointly explore improved approaches to address shared challenges. For example, there have been great strides in establishing intervention models for Early Psychosis, yet it is not clear on how many counties are using PEI funds to implement model, evidence based programs. To promote the use of evidence-based practices the Commission believes that it must first understand these models, identify potential barriers to implementation, and promote their adoption.

A PEI team, working within the regulatory framework required by AB 82 and in collaboration with the Commission's INN team, will allow the Commission to work with the counties to identify areas of shared concern and develop joint, regional or other shared approaches to services that allow California to make best use of evidence-supported PEI approaches as a strategy for system improvement.

Technical Assistance and Training. As mentioned above, the Commission has limited ability to provide assistance to counties across their PEI and INN components. There is tremendous variation in how counties are leveraging PEI and Innovation funding to guide improvements to California's mental health system. For instance, all counties are required to conduct community consultation processes, and every county is now required to conduct evaluations of each of their PEI programs. Preliminary assessments of county evaluations of programs and projects indicated wide variation in the quality of evaluations and the ability of counties to conduct evaluations that provide valid and reliable information appropriate for determining whether to sustain existing approaches to delivering services.

This proposal is intended to augment the Commission's technical assistance and training and increase the utility of PEI programs for improving county mental health programs and California's overall approach to mental health care.

Monitoring and Oversight. Both the Bureau of State Audits and the Little Hoover Commission have raised concerns that State-level entities have not exercised a sufficient level of oversight of county implementation of the goals of the MHSA. Existing Commission staff can provide only limited monitoring of county PEI expenditures or investigations associated with inappropriate use of PEI funding. The regulations require counties for the first time to provide PEI program-level measures of the duration of untreated mental illness (to assess outreach and engagement strategies and to better understand opportunities for and success in reducing the duration of prolonged suffering); the average time between client referrals to services and client participation in referred services (to assess access and linkage strategies); and detailed demographic characteristics of populations served (to better understand service penetration patterns, particularly for historically unserved and underserved populations).

The Commission states that these reporting requirements in turn create a significant workload burden for the Commission to ensure that the required data are properly received, processed, maintained and analyzed.

The Commission indicates that it is committed to working with stakeholders and the Department of Health Care Services to improve services, and using its oversight authority to develop PEI plans in accordance with the law and that PEI programs are adequately evaluated.

Information Dissemination. The MHSA includes a requirement for all counties to report on performance as a way to improve California's mental health system. Successful programs in one county can inform and guide investments across all counties. California must improve its ability to recognize and learn from the lessons of program evaluation, both successes and setbacks. There currently are no systematic, statewide efforts to disseminate information on best practices in PEI programming.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 8: CONTRACTS ADMINISTRATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Norma Pate**, Deputy Director, Mental Health Services Oversight & Accountability Commission
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Mental Health Services Oversight and Accountability Commission (Commission) is requesting $157,000 and one position, with funding from the Mental Health Services Fund (MHSF) to support the administration of expanded contract authority established under through the 2016 Budget Act. The 2016-17 budget increased the Commission's responsibility to administer stakeholder contracts, from a historical level of $1.9 million to $4.7 million annually. Additionally, the 2016-17 budget directed the Commission to develop and administer a one-time, $3 million grant program for children's crisis services. This request is to enable the Commission to administer these expanded obligations.

BACKGROUND

The Commission oversees the activities of statewide stakeholder advocacy contracts funded under Welfare and Institutions (W&I) Code Section 5892(d), These contracts support the needs of mental health clients, family members, children, transition aged youth, veterans, the LGBTQ community and organizations working to reduce racial and ethnic disparities through education, outreach and advocacy efforts.

These contracts, originally awarded on a sole source basis, were transferred to the Commission after the dissolution of the Department of Mental Health in 2011. Historically, the amount allocated for stakeholder contracts ranged from $300,000 to $669,000 per year, for a total of $1,954,000 per year, distributed between the following four populations: clients/consumers, children and youth, transition aged youth, and families of clients/consumers.

The 2015 Budget Act included in the Commission's budget an additional $1 million, subject to availability, to support enhanced mental health advocacy for transition aged youth, and to fund advocacy for veterans and racial and ethnic minorities. The Budget Act directed that those funds be awarded through a competitive process.

For the Fiscal Year 2016-17 budget, the Commission sought an additional $200,000 in funding to support a stakeholder advocacy contract for the LGBTQ community. That request was included in the Governor's 2016-17 proposed budget. Subsequent to that request, the Legislature voted to increase funding for each of the seven mental health advocacy contracts, including LGBTQ to $670,000, bringing the total contracted funds to $4,690,000 per year.

Stakeholder Contracts. Over the past year, the Commission has been working to fortify its administration of these contract dollars. These funds are essential for allowing consumers, family members and other target populations to have a voice in state and local decisions affecting access to mental health services and the quality of those services. As mentioned above, the Commission recently transitioned those contracts from a sole source contracting strategy to a competitive RFP process. The Commission released six separate RFPs in early 2016, and received between one and three applications for each of the six RFPs, for a total of 13 proposals. Three of the 13 proposals did not meet the technical qualifications outlined in the RFP and were rejected. Of the remaining proposals, only one surpassed the minimum qualifying threshold for consideration. In response, the Commission is working with stakeholder communities to encourage a greater level of interest in submitting proposals in response to the RFPs, and to provide additional technical assistance on the requirements of the RFP process. Later this year, the Commission will reissue the RFP process for the contract dollars that were not awarded during the initial RFP process.

Issuing the RFPs and establishing contracts, in more areas of advocacy as well as for a higher level of funding, will require the Commission to dedicate additional staff to this work. In 2012, when the Commission took over administration of these contracts from the Department of Mental Health, it absorbed the work within its existing staff. The commission states that the added contract dollars, paired with the need to provide additional technical assistance cannot be adequately addressed with the one staff member equivalent the Commission has been able to dedicate to this program. The Commission is requesting one additional staff person to meet these new contract administration responsibilities.

Children's Crisis Services. In addition to the increase in stakeholder contracts funds the Commission received, the 2016-17 Budget Act included an additional $3 million, one-time, to support a grant program for children's crisis services.

In 2015 the Commission initiated a project to explore the needs of children experiencing a mental health crisis. The Commission documented gaps in California's system of care for children in crisis. In response, the Legislature allocated an additional $30 million (one time) in MHSA funds to support children's crisis programs. The bulk of those funds were allocated to the California Health Facilities Financing Authority. The Commission received $3 million in one-time funds to support a competitive grant program for crisis services for children. The Commission states that it would be unable to effectively absorb this additional workload without reducing its work in other essential programs. This new program will require the Commission to establish grant requirements and administer a competitive process for counties to receive these funds. Although these

funds are one-time, the Commission anticipates the program will run between four and seven years from launch to completion.

In order to meet their obligations under the new contract authority established in the 2016-17 Budget Act, the Commission is seeking the funding and authority to hire one Associate Governmental Program Analyst, as an addition to the existing staff dedicated to administering stakeholder contracts and administering the other contracts funds allocated to the counties through a competitive process, namely the Commission's Triage Grant Program established under SB 82, the Mental Health Wellness Act, (Chapter 23, Statutes of 2013).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 9: MENTAL HEALTH WORKFORCE EDUCATION AND TRAINING (WET) PROGRAM OVERSIGHT AND STAKEHOLDER PROPOSAL

PANEL

- **Stacie Walker,** Deputy Director for the Healthcare Workforce Development Division**,** Office of Statewide Health Planning & Development
- **Rusty Selix**, Director, Public Policy & Advocacy, California Council of Community Behavioral Health Agencies
- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- County Behavioral Health Directors Association of California (*invited*)
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

OVERSIGHT ISSUE AND PROPOSAL

The Mental Health Workforce Education and Training (WET) program, established under the Mental Health Services Act, is reaching the end of its planned funding. Therefore, various stakeholders have raised questions about the future of this work, and concerns about the potential loss of the gains made by this project without establishing future plans and funding for on-going work in the area of the mental health workforce. This issue is to provide oversight on this issue as well as to consider a stakeholder proposal to require DHCS to develop regulations on this issue.

BACKGROUND

Established with the passage of Proposition 63, the Mental Health Workforce Education and Training (WET) programs were developed to address the growing need for a much more diverse public mental health workforce. Statute required a fund be created where revenues were deposited between Fiscal Years 2004-05 and 2007-08. At the end of the this period, a total of $444.5 million was allocated for the education and training portion of the MHSA. As of 2016 $114 million remained in the fund to fund statewide projects.

In 2008 the former Department of Mental Health (DMH), developed the first Five Year Plan which spanned April of 2008 – April of 2013; it was accompanied by a ten-year budget projection for the administration of the $444.5 million that had been collected in the WET fund. The budget set aside $210 million to be distributed to counties for local

WET program implementation to be expended by 2018 as well as $234.5 million set aside for the administration of WET programs at the State level.

In 2012, with the elimination of DMH, the MHSA WET programs were transferred to the Office of Statewide Health Planning and Development (OSHPD). OSHPD was tasked with the development of the next Five Year Plan that would be in effect from April 2014 – April 2019.

According to stakeholders, counties are reporting that the Stipend and Loan Repayment Programs set up through the State WET Funding are very popular. Data suggests that counties are reporting positive statistics about those utilizing these programs and some have reported that their workforce is indeed diversifying because of these programs.

Stakeholder shared with the Subcommittee that, according to the Riverside County MHSA Annual Plan Update for FY 2016-17, the Riverside County WET Graduate Intern, Field, and Traineeship (GIFT) Program reported that 66 students participated this fiscal year. Of those that participated were 44 MSWs, 13 MFTs, 6 BSWs, 2 Psy.D.s, and 1 Substance Use Counselor intern. Of the group 32 spoke a second language including Spanish, Farsi, Portuguese, Italian, and French.

They also provide that studies have shown that the mental health workforce is becoming more diverse. The California Pan Ethnic Health Network (CPEHN) cites a 2014 UCSF study that reported gains, especially in the fields of MSW and Counselors, of a more diverse workforce as recent as 2012 after the initial implementation of the WET State programs.

Proposal

The California Council of Community Behavioral Health Agencies (CCCBHA) proposes (MHSA) funding and trailer bill to require DHCS to draft and adopt regulations on the future of WET and mental health workforce development. Although OSHPD implemented the WET program, and therefore it might make the most sense for OSHPD to develop such regulations, CCCBHA states that only DHCS was given authority within the MHSA statute to develop such regulations.

CCCBHA states that one of the elements required to be in county MHSA plans is to identify the needs for workforce attraction and retention, and that counties need state guidance in this regard, particularly in light of the end of the WET program. Prop 63 intended for counties to set aside up to 20% of their services funding to continue the WET programs on their own after the 10 year funding period was over.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD provide an overview of the history, current status, and accomplishments of the WET program, and respond to the following:

1. What has been done to track county based programs?

2. Are there statistics that show how well county based WET programs are doing in diversifying the public mental health system (PMHS) workforce?

3. According to the guidelines of the stipend and loan repayment program, the recipients of the program dollars are only required to work in the PMHS for 1 year after obtaining the grants after which they are free to work anywhere. Is there data to show that participants of these programs are staying in the county PMHS workforce after their 1 year obligation is over?
4. Is the PMHS workforce progressively diversifying and being retained over longer periods of time?

5. Are there projections on what the workforce will look like in 10 years and will that workforce be reflective of the communities they are serving?

6. How will the ending of the WET funding impact the gains made in the diversification of the county PMHS workforce?

7. Is there any data to show how counties will cope with their own county WET programs after the funding is gone?

8. Will counties be able to offer the Stipend and Loan Repayment programs on their own, after relying so heavily on the state funded WET program?

9. What are the plans around continuing to develop the public mental health work force after WET funding is gone?

10. Are there plans to monitor the workforce development and diversification in the county PMHS after WET funding is gone?

11. After this funding is completely expended, will the WET component of MHSA simply disappear?

Staff Recommendation: Subcommittee staff recommends no action at this time.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 10: COMMUNITY MENTAL HEALTH SERVICES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

California has a decentralized public mental health system with most direct services provided through the county mental health system. Counties (i.e., county mental health plans) have the primary funding and programmatic responsibility for the majority of local mental health programs. This funding includes 1991 and 2011 realignment funding, Medi-Cal Specialty Mental Health General Fund and Federal Funds, and Mental Health Services Act (Proposition 63) funding, as shown in the following chart:

Community Mental Health Funding Summary

Fund Source	2015-16	2016-17	2017-18
1991 Realignment			
Mental Health Subaccount (base and growth)*	$128,837,000	$157,643,000	$200,561,000
2011 Realignment			
Mental Health Subaccount (base and growth)*	$1,127,247,000	$1,127,864,000	$1,129,876,000
Behavioral Health Subaccount (base)**	$1,168,395,000	$1,235,358,000	$1,308,486,000
Behavioral Health Growth Account	$66,964,000	$73,127,000	$93,254,000
Realignment Total	$ 2,491,443,000	$2,593,992,000	$2,732,177,000
Medi-Cal Specialty Mental Health Federal Funds	$2,279,073,000	$2,450,457,000	$2,700,176,000
Medi-Cal Specialty Mental Health General Fund	$ 151,199,000	$136,520,000	$187,983,000
Mental Health Services Act Local Expenditures	$1,418,778,000	$1,340,000,000	$1,340,000,000
Total Funds	$ 6,340,493,000	$6,520,969,000	$6,960,336,000

*2011 Realignment changed the distribution of 1991 Realignment funds in that the funds that would have been deposited into the 1991 Realignment Mental Health Subaccount, a maximum of $1.12 billion, are now deposited into the 1991 Realignment CalWORKs MOE Subaccount. Consequently, 2011 Realignment deposits $1.12 billion into the 2011 Realignment Mental Health Account.

**Reflects $5.1 million allocation to Women and Children's Residential Treatment Services. Includes Drug Medi-Cal.

BACKGROUND

Medi-Cal Mental Health. California has three systems that provide mental health services to Medi-Cal beneficiaries:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal "specialty" mental health services under a federal Medicaid Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21. County mental health plans are the responsible entity that ensures specialty mental health services are provided. Medi-Cal enrollees must obtain their specialty mental health services through counties.

2. **Managed Care Plans (MCPs) -** Effective January 1, 2014, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session expanded the scope of Medi-Cal mental health benefits and required these services to be provided by the Medi-Cal Managed Care Plans (MCP), excluding those benefits provided by county mental health plans. Generally, these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by the MCPs include:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

3. **Fee-For-Service Provider System (FFS system) -** Effective January 1, 2014 the mental health services listed below are also available through the Fee-For-Service/Medi-Cal provider system:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements

- Psychiatric consultation

Behavioral Health Realignment Funding

SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012, created the permanent structure for 2011 Realignment. SB 1020 codified the Behavioral Health Subaccount which funds Medi-Cal Specialty Mental Health Services (for children and adults), Drug Medi-Cal, residential perinatal drug services and treatment, drug court operations, and other non-Drug Medi-Cal programs. Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs and counties have the responsibility to provide for these entitlement programs.

Government Code Section 30026.5(k) specifies that Medi-Cal Specialty Mental Health Services shall be funded from the Behavioral Health Subaccount, the Behavioral Health Growth Special Account, the Mental Health Subaccount (1991 Realignment), the Mental Health Account (1991 Realignment), and to the extent permissible under the Mental Health Services Act, the Mental Health Services Fund. Government Code Section 30026.5(g) requires counties to exhaust both 2011 and 1991 Realignment funds before county General Fund is used for entitlements. A county board of supervisors also has the ability to establish a reserve using five percent of the yearly allocation to the Behavioral Health Subaccount that can be used in the same manner as their yearly Behavioral Health allocation, pursuant to Government Code Section 30025(f).

Mental Health Services Act (Proposition 63, Statutes of 2004)

DHCS plays a significant role in the administration and oversight of Proposition 63. Specifically, counties are required to submit annual expenditure and revenue reports to both DHCS and the MHSOAC. DHCS monitors county's use of Mental Health Services Act (MHSA) funds to ensure that the county meets the MHSA and MHS Fund requirements. DHCS works with counties to determine the county allocations, and is also the lead agency on the expenditures of MHSA State Administration funds, which are capped at 5 percent of total MHSA revenue.

MHSA Local Assistance January 2017 Dollars in Thousands			
	Actual	**Estimated**	**Projected**
	FY 2015-16	**FY 2016-17**	**FY 2017-18**
Local Assistance			
Department of Health Care Services • MHSA Monthly Distributions to Counties[1]	1,418,778	1,340,000	1,340,000
CSS (Excluding Innovation)	[1,078,271]	[1,018,400]	[1,018,400]
PEI (Excluding Innovation)	[269,568]	[254,600]	[254,600]
INN	[70,939]	[67,000]	[67,000]
Office of Statewide Health Planning and Development • WET State Level Projects (Not Including Mental Health Loan Assumption Program (MHLAP) funds)	15,972	30,174	12,650
Total Local Assistance	**1,434,750**	**1,370,174**	**1,352,650**

The following table shows where State Administration funds are expended and the table on the subsequent page describes the various uses of the MHSA State Administration funding as of January 2016 (updated information has not been provided yet in 2017):

MHSA State Administration

January 2017

(Dollars in Thousands)

	Actual	Estimated	Projected
	FY 2015-16	FY 2016-17	FY 2017-18
State Administration			
Judicial Branch	1,070	1,077	1,077
California Health Facilities Financing Authority • Mobile Crisis Services Grants	3,999	15,000	4,000
OSHPD – Administration	3,369	3,357*	3,372*
OSHPD – Non-Administrative State Operations (including MHLAP)	12,132	15,951	10,001
Department of Health Care Services	8,415	15,234	9,283
Department of Public Health	5,097	14,230	50,208*
Department of Developmental Services • Contracts with Regional Centers	1,222	1,142	1,142
Mental Health Services Oversight & Accountability Commission • Triage Grants beginning January 2014 ($32.0 M annually)	48,002	56,344	45,146
Department of Education	129	138	138
Board of Governors of the California Community Colleges	85	89	89
Financial Information System for California	188	150	135
Military Department	1,467	1,351	1,351
Department of Veterans Affairs • Provide information on local mental health services to veterans and families	506	505	505
University of California	3,564	9,800	0
Department of Corrections and Rehabilitation	0	233	229
Department of Housing and Community Development	0	6,200	0
Statewide General Administration**	0	2,701	2,867
Total Administration	**$89,245**	**$143,502**	**$129,543**
Total of Local Assistance and Administration	**$1,523,995**	**$1,513,676**	**$1,482,193**

* A portion of these funds were re-appropriated from prior year administrative funds and are attributed to the 5% administrative cap for a different fiscal year in which they are expended.

** Pro Rata assessment to the fund: General fund recoveries of statewide general administrative costs (i.e., indirect costs incurred by central service agencies) from special funds (Government Code sections 11010 and 11270 through 11275). The Pro Rata process apportions the costs of providing central administrative services to all state departments that benefit from the services.

Judicial Branch Positions for workload relating to mental health prevention and early intervention for juveniles in the juvenile court system. Positions to address workload relating to mental illness in adults in the criminal justice system.
California Health Facilities Financing Authority One-time MHSA funds for county mobile crisis personnel grants.
Office of Statewide Health Planning & Development Funds Statewide Workforce Education & Training (WET) program to develop mental health workforce.
Department of Health Care Services Funds the work of the Mental Health Services Division which provides fiscal and program oversight of MHSA. Funds staff of California Mental Health Planning Council which advocates for children and adults with serious mental illnesses, and advises the state on mental health issues. Provides statewide technical assistance to improve the MHSA.
Department of Public Health Funds staff for the California Reducing Disparities Project within the Office of Health Equity.
Department of Developmental Services Administer a statewide community-based mental health services system (via Regional Centers) for people with developmental disabilities.
Mental Health Services Oversight & Accountability Commission Funds oversight & accountability of the MHSA.
Department of Education Funds positions to increase capacity in staff and students to build awareness of student mental health issues and promote healthy emotional development. CDE is the student mental health contractor for CalMHSA to provide stigma reduction strategies.
Community Colleges Board of Governors Supports one position to develop policies and practices to address the mental healht needs of community college students.
Financial Information System for California (FI$Cal) Supports the development of FI$Cal, the state's integrated financial management system, used by state agencies with accounting systems.
Military Department Funds 8.2 positions for provide 24/7 support for a behavioral health outreach program to improve coordination between the California National Guard, local County Veterans' Services Officers, county mental health departments, and others to meet mental health needs of guard members and their families.
Department of Veterans Affairs Funds 2.0 positions to inform veterans and their family members about federal benefits, local mental health department services, and other mental health services. Administers grant programs to improve mental health services to veterans, develops Veteran Treatment Courts, and educates incarcerated veterans about benefits and services.
University of California One-time funds for two Behavioral Health Centers of Excellence (at UCLA and UCD) for research on behavioral health care and the integration of medical and mental health services.

MHSA State Admin Cap *(Dollars in Thousands)*			
FY	**Admin Cap**	**Expenditures**	**Available In Cap**
2012-13	$58,965	$31,572	$27,393
2013-14	$64,111	$39,474	$24,637
2014-15	$91,574	$78,989	$12,585
2015-16	$90,358	$78,245	$12,113
2016-17	$93,212	$119,703	($26,491)
2017-18	$94,439	$119,542	($25,103)
Cumulative Total	**$492,667**	**$467,525**	**$25,142**

Specialty Mental Health Waiver

While the SMHS Waiver previously had been approved for only two years at a time, CMS has approved the new SMHS Waiver for five years. This is the first time CMS has granted a five year SMHS Waiver renewal to California. However, CMS approved the Waiver on the condition that DHCS meets newly imposed Special Terms and Conditions (STCs), which involve current functions as well as new functions and increased workload. Failure to comply with these STCs places the SMHS Waiver, and up to $2 billion in federal funds at risk.

On June 24, 2015, CMS issued an approval of the five-year SMHS Waiver and indicated that their concerns continue to be program Integrity monitoring and compliance. This renewal is effective July 1, 2015 through June 30, 2020. The STCs will require a substantial increase in workload, over and above current workload. As in prior years, ongoing non-compliance issues and chart review disallowances by the County MHPs remain. In the renewal, CMS has given specific expectations for DHCS to attain compliance with federal and state regulatory requirements as well as the MHP contract requirements, including a process for levying fines, sanctions, and penalties on MHPs that have continued, significant non-compliance issues. DHCS is in the process of developing a performance dashboard that mirrors the Performance Outcome System for children.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of community mental health programs, an update on the budget for these programs and services, and respond to the following:

1. Please explain the negative amounts shown in the chart above for the amounts available in the MHSA State Admin cap in 2016-17 and 2017-18.

2. How does the state provide oversight over county use of MHSA funds? How do we know how the funds are being spent, and if they are being spent in effective and efficient ways?

3. Please describe the new performance outcome system being developed under the SMHS waiver.

4. Given the realignment of mental health services to counties, how does the state provide oversight and ensure that adequate high quality mental health treatment is accessible to the Medi-Cal population?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 11: DELAYS IN IMPLEMENTATION OF THREE BILLS (TRAILER BILL)

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Karen Baylor,** PhD, LMFT, Deputy Director, Mental Health Services And Substance Use Disorder Services, Department of Health Care Services
- **Jessica Sankus**, Junior Staff Analyst, Department of Finance
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- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

In order to manage and prioritize workload, DHCS is proposing (or announcing) delays to the implementation of six bills. As indicated below, three of these require legislative authorization, and DHC has proposed trailer bill for this purpose, while the other three can be delayed under the current authority of the administration. This issue today covers just three of the six that relate to mental health; the other three proposals have been or will be heard on another hearing date. The six proposals are:

1. Implementation of the Whole Child Model for CCS in COHS counties (SB 586) to no sooner than July 1, 2018. *This proposal does not require legislative authorization. This issue was heard by the Subcommittee on* ***March 27, 2017****.*

2. Implementation of the palliative care program (SB1004) to no sooner than July 1, 2018. *This proposal does not require legislative authorization. This issue was heard by the Subcommittee on* ***March 27, 2017****.*

3. Implementation of the inclusion of marriage and family therapists as billable FQHC providers (AB 1863) to no sooner than July 1, 2018. *This proposal requires legislative authorization (trailer bill). This proposal is being heard today,* ***April 3, 2017****.*

4. Issuance of regulations for out-of-county foster care presumptive transfer (AB 1299) to July 1, 2020. *This proposal requires legislative authorization (trailer bill). This proposal is being heard today,* ***April 3, 2017***.

5. Issuance of evaluation report for Assisted Outpatient Treatment (AB 59) to no sooner than July 1, 2018. *This proposal requires legislative authorization (trailer bill). This proposal is being heard today,* ***April 3, 2017***.

6. Implementation of the FQHC alternative payment methodology pilot to no sooner than January 1, 2018. *This proposal does not require legislative authorization. This proposal will be heard by the Subcommittee on* ***May 1, 2017***.

BACKGROUND

DHCS included the following explanation of their proposal to delay implementation of these six bills:

> **"DHCS Priorities** Given the challenging budget environment and the multitude of new programs, federal regulations and other efforts, the Department must prioritize certain initiatives and delay others. The Department must prioritize the implementation of the various federal regulations that continue to be resource-intensive, such as the Medicaid managed care, Medicaid mental health parity, and home and community based services regulations. In addition, the Department also must prioritize the ongoing stability of our programs and the necessary day-to-day work that enables Medi-Cal and our other programs to operate effectively and serve our beneficiaries.
>
> The Department has specifically identified initiatives that must be delayed, as noted below, and will continue to evaluate priorities to most effectively and efficiently operate our programs. In some instances, the Department is proposing specific statutory delays, when necessary, to align the timelines in statute with when the Department will be able to implement."

Implementation of the inclusion of marriage and family therapists as billable FQHC providers (AB 1863) to no sooner than July 1, 2018

AB 1863 (Wood, Chapter 610, Statutes of 2016) added marriage and family therapists (MFTs) to the list of eligible billable providers for FQHCs effective January 1, 2017. In order to effectuate this change, DHCS would be required to take several actions, including but not limited to developing a state plan amendment (SPA); developing policies and procedures for FQHCs; and responding to requests for changes in scope of service to add MFTs as billable providers.

Under this proposal, FQHCs would not be permitted to bill Medi-Cal for MFT visits until July 1, 2018. DHCS states that this delay in timeline is necessary given the significant DHCS staff resources that would be required to implement this change. Given the budget challenges and multitude of priorities, DHCS is unable to devote the necessary staff time to complete the work needed to effectuate the inclusion of MFT visits as billable visits any sooner than July 1, 2018.

Issuance of regulations for out-of-county foster care presumptive transfer (AB 1299) to July 1, 2020

AB 1299 (Ridley-Thomas, Chapter 603, Statutes of 2016) requires development of regulatory procedures for transferring the financial responsibility and provision of Medi-Cal Specialty Mental Health Services (SMHS) when a foster child is placed in a host county. These regulatory procedures are described as “presumptive transfer.” AB 1299 requires DHCS to do the following:

- Establish presumptive transfer as a policy by July 1, 2017, in consultation with California Department of Social Services (DSS) and with the input of stakeholders that include County Welfare Directors Association of California

(CWDA), Chief Probation Officers of California (CPOC), County Behavioral Health Directors Association of California (CBHDA), provider representatives, and family and youth advocates;
- Issue policy guidance that establishes presumptive transfer procedures.
- Establish procedures for expedited transfer within 48 hours; and
- Adopt regulations by no later than July 1, 2019.

To provide timely and effective mental health services for all foster children placed outside of their county of child welfare and/or probation jurisdiction, DHCS has worked in consultation with stakeholders including the DSS, CBHDA, CWDA, CPOC, County Mental Health Plans, and the California Child Welfare Council, to develop procedures regarding foster children who are placed outside of their county of jurisdiction. These procedures would allow foster children in host counties to receive medically necessary and timely SMHS.

DHCS is working to issue policy guidance before July 1, 2017, in accordance with the provisions of AB 1299. However, DHCS cannot absorb the workload to adopt regulations in a timely manner. Therefore, DHCS proposes to extend the date for DHCS to adopt regulations from July 1, 2019, to July 1, 2020. Although the adoption of regulations would be extended to July 1, 2020, DHCS will issue written guidance on the presumptive transfer policy and procedures by July 1, 2017; allowing counties to implement presumptive transfer beginning July 1, 2017.

Issuance of evaluation report for Assisted Outpatient Treatment (AB 59) to no sooner than July 1, 2018

Enacted in 2002, the Assisted Outpatient Treatment Program (AOT) Demonstration Project Act, also known as "Laura's Law," was named after Laura Wilcox, a 19-year old Nevada County college student killed by a severely ill man who was not compliant with prescribed mental health treatment. Laura's Law authorizes a County's Board of Supervisors, through the resolution process, to fund AOT services using money allocated to them from various sources, including the Local Revenue Fund and Mental Health Services Fund. If a resolution is passed and the county opts to implement the AOT Program, courts in participating counties may order a person into treatment. An individual may be determined in need of AOT services from a number of factors including, but not limited to, the following:

- a person's recent history of hospitalization or violent behavior;
- a person who refused voluntary treatment;
- whether a person's mental health condition is substantially deteriorating indicating that they are likely to become dangerous or gravely disabled without the court ordered outpatient treatment; or
- whether AOT would be the least restrictive level of care necessary to ensure the person's recovery and stability in the community.

AB 59 (Waldron, Chapter 251, Statutes of 2016) extended the sunset date for the AOT Demonstration Project from January 1, 2017, to January 1, 2022. The extension continued DHCS's requirement to provide an annual evaluation report of California's AOT programs to the Governor and Legislature.

Although DHCS is supportive of counties continuing AOT program services until January 1, 2022, the Department cannot absorb the workload to collect and analyze data collected by counties' AOT programs, as required by existing law, to produce the annual evaluation report (Welfare & Institutions Code Section 5348(d)) in 2017. Thus, DHCS proposes to delay the submission of the annual report to the Governor or Legislature until July 1, 2018. Although DHCS will not be collecting or evaluating data reporting by counties' AOT programs, counties' AOT programs and services may still continue.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present their proposed trailer bill to delay implementation of AB 1863, AB 1299, and AB 59, and respond to the following:

1. How much resources would be needed to implement these bills?

2. How many counties have opted to implement AOT?

3. Will there be any delay to the implementation of out-of-county foster care placement services (AB 1299) as a result of delaying the regulations?

4. What is the expected increase in access to mental health services as a result of the implementation of AB 1863, and therefore how much increased access will be delayed by delaying the implementation of this bill?

Staff Recommendation: Subcommittee staff recommends adopting modified trailer bill related to AB 1863 that requires implementation no sooner than, and no later than, July 1, 2018. Subcommittee staff recommends no action at this time on the proposed trailer bills related to AB 1299 and AB 59.